STRAIGHT (H.S.)

SYPHILIS AND "APEX-CATARRH."

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SYPHILIS AND "APEX-CATARRH."

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CASES of syphilis and apex catarrh are of frequent occurrence and of great importance. My knowledge of this class of cases has been obtained by observation. There is, I think, little literature upon the subject. The importance of an early recognition of all the factors in such cases was impressed upon me a number of years ago, and a longer experience has only confirmed my opinion. No better name for this class of cases has suggested itself than that chosen. The term, mixed infection of syphilis and tuberculosis, has been suggested, but the catarrh at the apex or apices of the lungs is non-tuberculous, and remains so in the majority of cases. If the catarrh at the apex lowers the vitality and resistance of the cells sufficiently to admit the growth and development of the tubercle-bacillus a localized tuberculosis results. As I have observed, the great majority of these cases of apex-catarrh recover, and the most reasonable explanation of their pathology is that they are simply catarrhal in character. Why such a small proportion of cases of apex-catarrh become tuberculous is not explained. Most cases recover within a few months. The explanation may be that the vitality of the cells is not sufficiently

lowered to make possible the growth and development of the tubercle-bacillus.

CASE I.—Four years ago I was consulted by a woman forty-five years of age, who had separated from her husband fifteen years before on account of his bad habits. Her sister, a few years younger, had been under my care for three months with an apex-catarrh, and had improved very much. Upon comparing symptoms they concluded that they both had the same disease. The elder sister had been under the care of two very competent physicians for about two months. She had had a large specific ulcer on the pharynx, and a syphilitic periositis of each tibia. Her suffering from the pain had been intense in the beginning. The ulceration of the pharynx had healed. The active manifestations of the periostitis had also disappeared, but the part was still tender on gentle percussion. Her medication had been mixed treatment with anodynes when necessary.

Within three months she had lost fifteen pounds in flesh. She was slightly anemic, and her tongue showed a disturbance of the gastro-intestinal tract. Her pulse was 96, and the temperature was 99.6°. Examination of the chest revealed in the left infra-clavicular region a well-marked apex-catarrh. At the right apex much less could be detected, although she had transference of heart-sounds and suspicious auscultatory signs. The specific treatment was not changed, and in addition she was given creosote, at first in doses of ℥jss, four times a day, and later in double this dosage. She improved promptly. She was kept under continuous observation for five months, during three of which she had a slight rise of temperature in the afternoon and evening. After this time she ceased her visits, as she considered herself

well. After discontinuing her medicine for two months she began to feel badly again, and returned, and she was again put upon the old treatment, with prompt improvement, and her treatment was continued for two months. For two years she would occasionally return whenever she began to feel badly again, and would take her medicine for a few weeks, and then would cease her visits. When last seen her chest-signs had completely disappeared.

Slight fever in late syphilis occurs, but it disappears within a few days under anti-syphilitic treatment. This patient had had such treatment for weeks, and my treatment was not different as far as the specific disease was concerned. The disease at the apex had simply been overlooked.

Case XI.—An intelligent woman, twenty-five years old, married one year, came under my care in the John Huntington Dispensary in May, 1894. She had lost flesh markedly, was quite anemic, had felt depressed, and had tired easily for six months. Her menses had been regular and normal. She made no special complaint except as to the throat; the temperature was 100°; and the pulse 108. She had an ulceration as large as a quarter-dollar at the upper part of the oro-pharynx, and also an induration of the upper lip. Four years before she had had an ulcer and an induration of the lip, which had never altogether disappeared. The induration and enlargement had become more marked during the two months before she came under observation. They were undoubtedly specific, but this fact had been overlooked or had escaped notice, and she had received no constitutional treatment. When the induration upon the lip first occurred she had had no other manifestations of syphilis, nor at any time later

until the ulcer appeared. She disclaims any knowledge as to the mode of contagion. When first seen the induration of the lip was as large as the tip of the little finger, and this and the ulcer in the throat were the only manifestations of the disease. Chest-examination revealed a bilateral apex-catarrh, most marked on the left. She was given mixed treatment and creosote. The improvement in the specific manifestations was rapid, but it was a number of weeks before the depression became notably less marked. The improvement of the ulcer and induration of the lip was as rapid as in an uncomplicated case. The temperature continued at about 100° for three months; the pulse was slightly rapid for a few weeks, and at the present time pulse and temperature are normal. She has gained a few pounds in flesh and very much in strength; and the chest-signs have become stationary. She still has transference of heart-sounds, slight cog-wheel breathing, shortened inspiration, etc. She should continue the creosote for months, as well as the mixed treatment. She will recover so far as the chest-complication is concerned. My reason for this statement is that the catarrhal process began at the left apex, and progressed to a certain point; it then began at the right apex, and the progression at the left ceased and has begun to clear up. When a case of apex-catarrh becomes an incipient pulmonary tuberculosis the physical signs at the apex at which the disease first occurred always continue more marked than at the other apex. I have watched this class of cases for years, and have never seen an exception to this rule.

Case III.—A girl twenty-two years of age was sent to my department in the Dispensary, April 23, 1894. Six weeks before, she had been admitted to the Infirmary Hospital of Cleveland, and for a

month before going to the infirmary she had had two ulcers upon the genitals. When admitted she still had the local sores and rheumatism in the right knee. The ulcers healed in a short time under local treatment only. She took something for the pain in her knee, but when the symptoms passed away the medicine was discontinued. Upon obtaning this history my conclusion was that the lesions upon the genitals had been considered chancroidal. She came complaining of her throat, presenting a general slight inflammation of the pharynx and larynx, but nothing characteristic of syphilis. The temperature was 99°, the pulse 90. She had no other manifestation of syphilis. Examination of the external genitals yielded only negative evidence. She still complained of some pain and tenderness in the right knee, worse at times, and she was slightly anemic. Up to the time of entering the infirmary she had felt well. Since that time she had felt tired and less vigorous than usual. The chest-examination revealed next to nothing, but the condition of the left apex was suspicious. Whether there was a slight transference of heart-sounds was doubtful. The diagnosis made was subacute rheumatism of the right knee and pharyngo-laryngitis. Whether the inflammation of the pharynx and larynx was a local manifestation due to rheumatism, or the local manifestation of a developing syphilis, or the local catarrhal condition that so often precedes any positive chest-signs in a developing apex-catarrh, or a local inflammation simply, was the question to decide, and it was impossible to decide it. As far as the possible syphilitic element was concerned, I concluded to wait. She was given sodium salicylate and creosote, and the throat was painted with silver nitrate. The case was seen daily for a short time. The second day the pulse

was still 90, but the temperature was 99.3°. The slight rapidity of the pulse and the slight rise in temperature continued on succeeding visits. The pain in the knee promptly disappeared, and the throat-symptoms were somewhat relieved; but after watching her for a few days I became convinced that there was something more in the constitutional condition than had yet appeared. Whether it was a developing apex-catarrh, or syphilis, or both, could not be decided. After observing the case for ten days the patient developed unmistakable syphilitic manifestations: an eruption about the mouth, a mucous patch upon the right tonsil, and an ulceration and induration in the fourchet. The sodium salicylate was stopped and mercuric chlorid was substituted. A reëxamination of the chest revealed nothing positive. The question still concerned the left apex. Temperature and pulse remained as before. There was no change in either after the patient had taken anti-syphilitic treatment for two weeks. The local specific manifestations rapidly disappeared, but the throat-symptoms remained much the same. There was a loss of five pounds in flesh the first three weeks after the woman came under observation. The chest was examined every ten days. The creosote had been continued because the temperature did not fall to the normal after the ordering of the bichlorid. Five weeks after the first visit the physical signs at the left apex became positive. She had an apex-catarrh. From this time the catarrh at the apex pursued the ordinary course. After two months the patient began to gain flesh and strength. She had, however, slight fever and rapidity of pulse for fully four months after first presenting herself. Her medication has consisted of mercury and creosote. The chest-signs have nearly disappeared. The specific manifestations disappeared according to the rule.

The diagnosis in this case was certainly very much mixed. Viewing the case after five months' treatment the course adopted in the start was certainly wise. The slight fever was important, as it occurs in patients with a developing syphilis, but it subsides within a week after the administration of a mercurial. It also occurs in patients who are developing an apex-catarrh, although the pulse may be normal. While the slight fever in syphilis disappears almost at once under mercury, the slight fever in an apex-case continues for weeks, perhaps months, in spite of every treatment. Patients with a developing apex-catarrh also have slight fever sometimes for weeks before a positive opinion can be given as to the physical signs.

Whether there is necessarily any connection between the syphilis and the apex-catarrh in cases like these is a doubtful question. It would be a reasonable inference to believe that the apex-catarrh developed because of the depressing effects of the syphilitic poison. Apex-catarrh certainly occurs as a result of lowering conditions, but only in a small proportion of syphilitic patients. I see so many cases of apex-catarrh in patients in whose life and surroundings no adequate cause for such development appears that I have wondered whether its occurrence in the syphilitic patient might not be a coincidence. It has also been questioned whether the local inflammation of the capillary bronchial tubes might not be due to the efforts of Nature to eliminate the poison due to syphilis through this part of the body. This does not seem reasonable, because an apex-catarrh only exceptionally occurs in syphilitic cases. I could much more easily understand

how the catarrh at the apex in Cases I and II could be due to the specific poison than in Case III, in which the manifestations seemed almost earlier than the specific manifestations. If this condition of mixed infection occurred most often in delicate patients, one could better understand how the one might be due to the other. But this has not been my experience. The prognosis as to the apex-catarrh seems to be as good as in an uncomplicated case.

Although this statement does not seem reasonable, I have yet to see, however, a case of apex-catarrh in a syphilitic that did not recover. Each condition ought to be treated as if the other did not exist. Creosote, or one of its derivatives, is the best remedy for the catarrh. Patients recover, however, under any form of tonic treatment. Creosote relieves the subjective symptoms better than any other remedy with which I am acquainted, and is a brilliant remedy in such conditions. The physician who treats these cases of mixed infection with antisyphilitics and tonics, and knows nothing of the catarrh at the apex, will, perhaps, have as good results as any one; but the attendant who discovers all the factors in the case is certainly in a better position to deal wisely with his case. If the temperature and pulse are not carefully observed the physician may not even suspect any chest-complication. The slight anemia and all the other symptoms of an apex-catarrh are so easily accounted for in a patient who has syphilis that one's eyes may be blinded to any other constitutional condition. The complications noted in these three cases certainly explain the reason why a certain proportion of syphilitic cases pursue an unusual course.